Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse or doctor to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	____	____	____
2. Is the child taking any medication?	____	____	____
3. Does the child have allergies to medications, food, or any vaccine?	____	____	____
4. Does the child have any long-term health concerns?	____	____	____
5. Has the child had a serious reaction to a vaccine in the past?	____	____	____
6. Has the child had a seizure or a brain problem?	____	____	____
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	____	____	____
8. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months?	____	____	____
9. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	____	____	____
10. Is the child/teen pregnant or breastfeeding or is there a chance she could become pregnant or breastfeed in the next month?	____	____	____
11. Has the child received any vaccinations in the past 4 weeks?	____	____	____
12. Has the child ever fainted from having blood drawn or an injection?	____	____	____
13. For children receiving influenza vaccine: Was the child ever paralyzed by Guillain-Barre Syndrome?	____	____	____

Form completed by: _____ Date: _____

Comments_____ RN Initials_____

Adapted from Immunization Action Coalition • 1573 Selby Avenue • St. Paul, MN 55104 • (651) 647-9009 www.immunize.org